Electronic Health Record (EHR) Incentive Program

Eligible Professional Supporting Documentation for Attestation and Audit

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Agenda

- Background

- What to Upload at Attestation

- Documentation to Support Meaningful Use Attestations

- Reminders and Best Practices

- Questions

Eligible Professional Supporting Documentation for Attestation and Audit

Background

Medicaid EHR Incentive Program Background

- Established in Section 4201 of the *American Recovery and Reinvestment Act of 2009*.

- The act provides incentive payments to certain types of Medicaid providers who adopt and become meaningful users of electronic health records.

Medicaid EHR Incentive Program Background

The incentive program is a piece of broader health information technology infrastructure needed to:

- Improve quality, safety, and efficiency, and reduce health disparities.

- Engage patients and families.

- Improve care coordination.

- Improve population and public health.

- Ensure adequate privacy and security protection for personal health information.

Wisconsin Medicaid EHR Incentive Program Background

- Wisconsin started accepting applications and making incentive payments in Program Year 2011.

- Wisconsin received guidance from the Centers for Medicare and Medicaid Services (CMS) that documentation to support attestations should be required prior to issuing payment in an effort to avoid fraud, waste, and abuse.

Note: Access to this information for administrative and payment purposes is allowed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Wisconsin Medicaid EHR Incentive Program Policy Change

- Starting in Program Year 2015, Eligible Professionals must submit documentation supporting their attestation with their application. This includes:

    o Documentation supporting the certified EHR technology (CEHRT) adopted or in use during the program year.

    o Documentation supporting the patient volume calculation.

- All Eligible Professionals must submit this documentation regardless of their year of participation in the program.

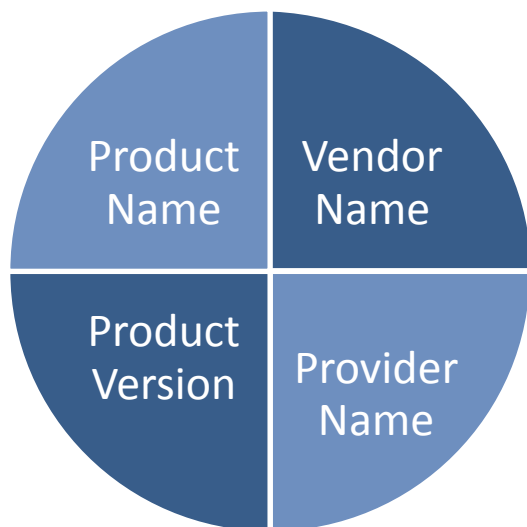Eligible Professional Supporting Documentation for Attestation and Audit
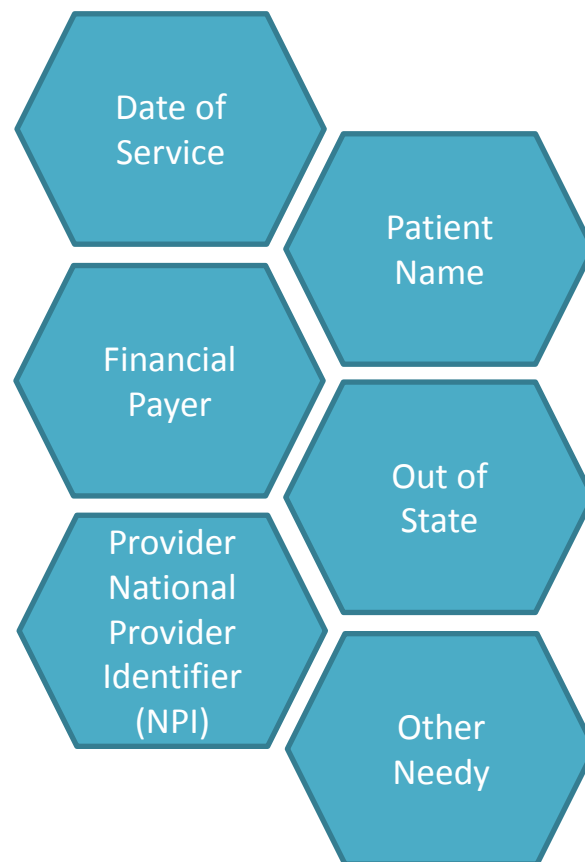
What to Upload at Attestation

What to Upload at Attestation (Required Documentation)

Certified EHR Technology (CEHRT)

Product Name | Vendor Name
Product Version | Provider Name

Patient Volume

- Date of Service
- Patient Name
- Financial Payer
- Out of State
- Provider National Provider Identifier (NPI)
- Other Needy

Required CEHRT Documentation

- Documentation must reflect CEHRT reported on the application by the CMS EHR Certification ID.

- Documentation must indicate that CEHRT was adopted, implemented, upgraded, or in use during the program year.

Note: Visit the [Required Documentation](#) page for details on CEHRT documentation requirements.

Required CEHRT Documentation

- Submit one or more of the following:
  - o Contract
  - o Lease
  - o Proof of purchase
  - o Receipt
  - o Vendor letter (signed and dated by vendor)
  - o System screenshot (may be submitted in addition to one of the above items)

Note: Visit the [Required Documentation](#) page for details on CEHRT documentation requirements.

Required Patient Volume Documentation: Detail and Summary Reports

- **All** Eligible Professionals must submit the detail report (regardless of the choice to attest using individual or group patient volume method). The detail report must contain **every** encounter during the patient volume reporting period:

Detail Report Example (All EPs)						
Rendering Provider Name	Rendering Provider NPI	Patient Name	Medicaid ID	Date of Service	SMA (Out of State Encounter)	Payer
Laurence Olivier	9999999999	Audrey Seymour	1000008	6/8/2015		Medicaid
Laurence Olivier	9999999999	Nick Snape	4444444	6/10/2015		Medicaid
Laurence Olivier	9999999999	Lilian Snape	55555554	6/8/2015	Iowa	Medicaid

- In addition, the summary report must be submitted for providers using group patient volume method:

Summary Report Example (Group EPs)				
Rendering Provider Name	Rendering Provider NPI	Medicaid Encounters	Needy Encounters	Total Encounters
Laurence Olivier	9999999999	222	28	332
Vivian Leigh	2222222222	354	35	412
Anthony Maria	3333333333	123	154	289
Anita Jette	4444444444	21	554	603
	TOTALS:	720	771	1,636

Note: Visit the Required Documentation page for details on patient volume documentation requirements.
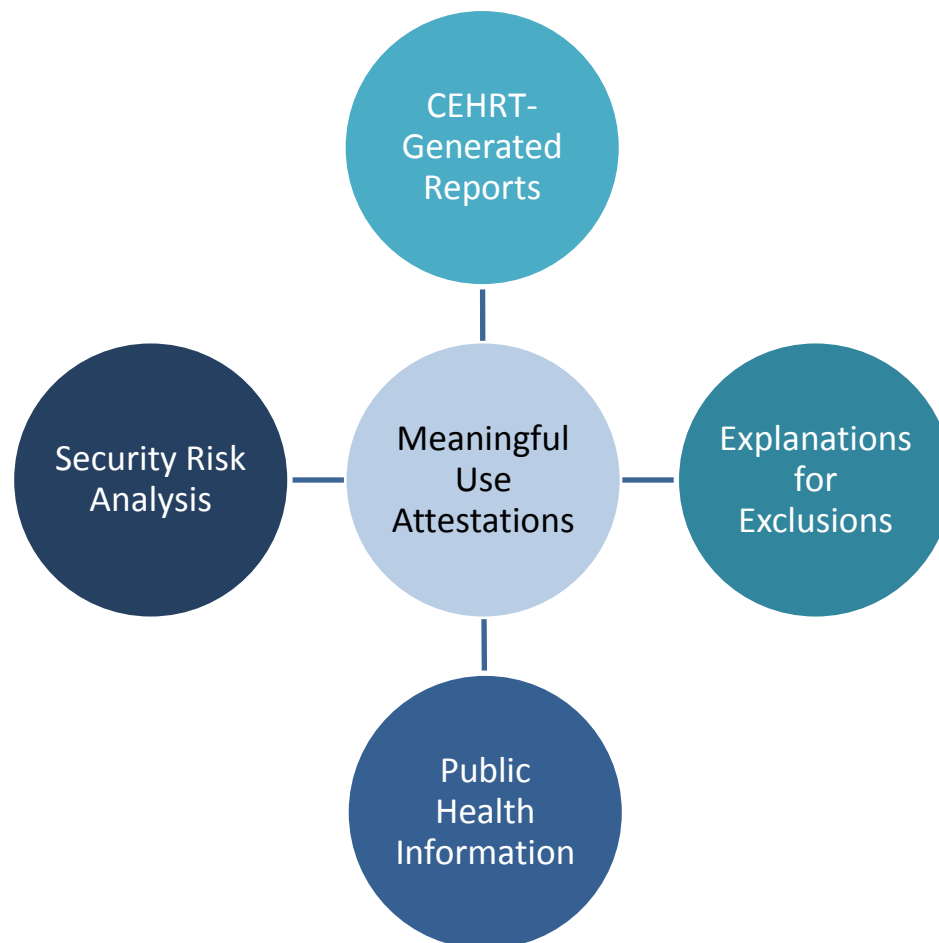
What to Upload at Attestation (Optional Meaningful Use Documentation)

✓ Uploading documentation expedites your application processing.

✓ Uploading Meaningful Use documentation is optional for Program Year 2015.

CEHRT-Generated Reports

Security Risk Analysis

Meaningful Use Attestations

Explanations for Exclusions

Public Health Information

Eligible Professional Supporting Documentation for Attestation and Audit

Documentation to Support Meaningful Use Attestations

Meaningful Use Response Types

Eligible Professionals have three different types of responses to Meaningful Use measures:

- Numerators and denominators (percentage based)

- Yes or No

- Attest to exclusions

Note: Some measures have one or more exclusions to which Eligible Professionals may attest to indicate that a measure is not applicable to them or they do not have the necessary patient population needed to fulfill the measure requirements.

Meaningful Use Source Documentation

EHR Source Data: Documentation derived from the CEHRT system	Non-EHR Source Data: Any additional documentation used to attest that is not derived from the CEHRT system
CEHRT-generated reports displaying the numerators and denominators	Clinical policy and procedure documentation
Sample of a Medicaid patient's electronic medical record	Written explanations
Screenshots from CEHRT	Security risk analysis
Audit logs from CEHRT	Documentation from the Wisconsin Division of Public Health (DPH)

Documentation for Percentage Based Measures (Objectives 3 Through 8)

EHR Source Data	Non-EHR Source Data
CEHRT-generated reports displaying the numerators and denominators	Clinical policy and procedure documentation
Screenshots to demonstrate required functionality	
Sample of a Medicaid patient's electronic medical record	Written explanations
Audit logs validating actions (for example, exchange of clinical summaries)	

Note: See the Appendix for a description of supporting documentation for Modified Stage 2 Meaningful Use objectives and measures for Program Years 2015 through 2017.

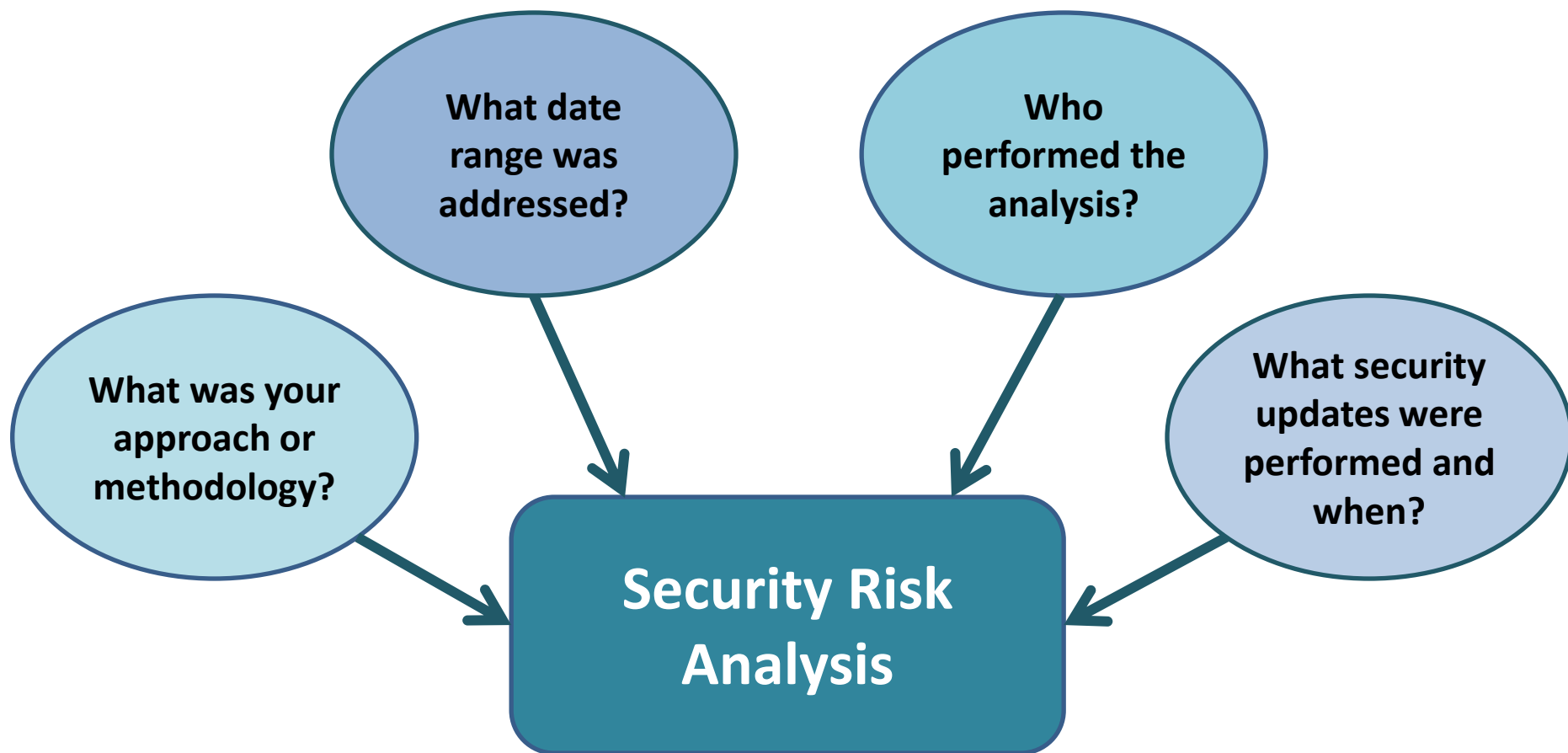# Documentation for Yes or No Measures (Objectives 1, 2, 9, and 10)

EHR Source Data
Screenshots to demonstrate required functionality
Audit logs validating actions (for example, enabling clinical decision support interventions)

Non-EHR Source Data
Clinical policy and procedure documentation
Written explanations
Documentation from the Wisconsin DPH
Security risk assessment
Letter from EHR vendor

Note: See the Appendix for a description of supporting documentation for Modified Stage 2 Meaningful Use objectives and measures for Program Years 2015 through 2017.

Documentation for Yes or No Measures (Objective 1 Example)

What date range was addressed?

Who performed the analysis?

What was your approach or methodology?

What security updates were performed and when?

Security Risk Analysis

Documentation for Yes or No Measures (Objective 2 Example)

A combination of the below items can be used to support the drug-drug and drug-allergy interaction check functionality.

Audit Log	Screenshots	Vendor Letter
Date/time stamp showing when the functionality was enabled	Out of CEHRT demonstrating use of the functionality	Date functionality was enabled and whether functionality can be turned off once enabled

Documentation for Yes or No Measures (Objective 10 Example)

Wisconsin Public Health Programs	Specialized Registries Outside of Wisconsin DPH
• Acknowledgements file for applicable public health registry • [Acknowledgements Files page](#)* of the Public Health Registration for Electronic Data Submission System (PHREDS) • Emails from the applicable registry and/or Wisconsin DPH (dhssharepoint@dhs.wisconsin.gov) *Link will work only if you have access to the PHREDS system. Visit the [PHREDS Enrollment and Registration of Intent page](#) for instructions on gaining access.	Must be able to provide proof of: • Registration of intent to submit data • Testing and validation activities • Submission of production data to the registry

Documentation for Exclusions (Objectives 2 Through 10, as Applicable)

EHR Source Data	Non-EHR Source Data
CEHRT-generated reports displaying a 0 for the denominator	Clinical policy and procedure documentation
	Information on scope of practice
	Written explanations

Note: See the Appendix for a description of supporting documentation for Modified Stage 2 Meaningful Use objectives and measures for Program Years 2015 through 2017.

Summary of Meaningful Use Documentation

| Objective	Attestation Type	Source Type	Supporting Documentation
Objective 1: Protect Patient Health Information	Yes or No	Non-EHR	Security risk analysis
Objective 2: Clinical Decision Support	Yes, No, or Exclusion	Non-EHR	Policy and procedure documentation
		EHR	CEHRT screenshots
Objective 3: Computerized Provider Order Entry	Percentage Based or Exclusion	Non-EHR	Policy and procedure documentation
		EHR	CEHRT-generated reports
Objective 4: Electronic Prescribing	Percentage Based or Exclusion	EHR	CEHRT-generated reports and screenshots
Objective 5: Health Information Exchange	Percentage Based or Exclusion	EHR	CEHRT-generated reports
Objective 6: Patient-Specific Education	Percentage Based or Exclusion	EHR	CEHRT-generated reports
Objective 7: Medication Reconciliation	Percentage Based or Exclusion	EHR	CEHRT-generated reports
Objective 8: Patient Electronic Access	Percentage Based or Exclusion	EHR	CEHRT-generated reports and screenshots
Objective 9: Secure Electronic Messaging	Yes, No, or Exclusion	EHR	CEHRT screenshots
Objective 10: Public Health Reporting	Yes, No, or Exclusion	Non-EHR	DPH acknowledgments

What to Upload at Attestation (Optional Meaningful Use Documentation)

✓ Uploading documentation expedites your application processing.

✓ Uploading Meaningful Use documentation is optional for Program Year 2015.

CEHRT Generated Reports

Security Risk Analysis

Meaningful Use Attestations

Explanations for Exclusions

Public Health Information
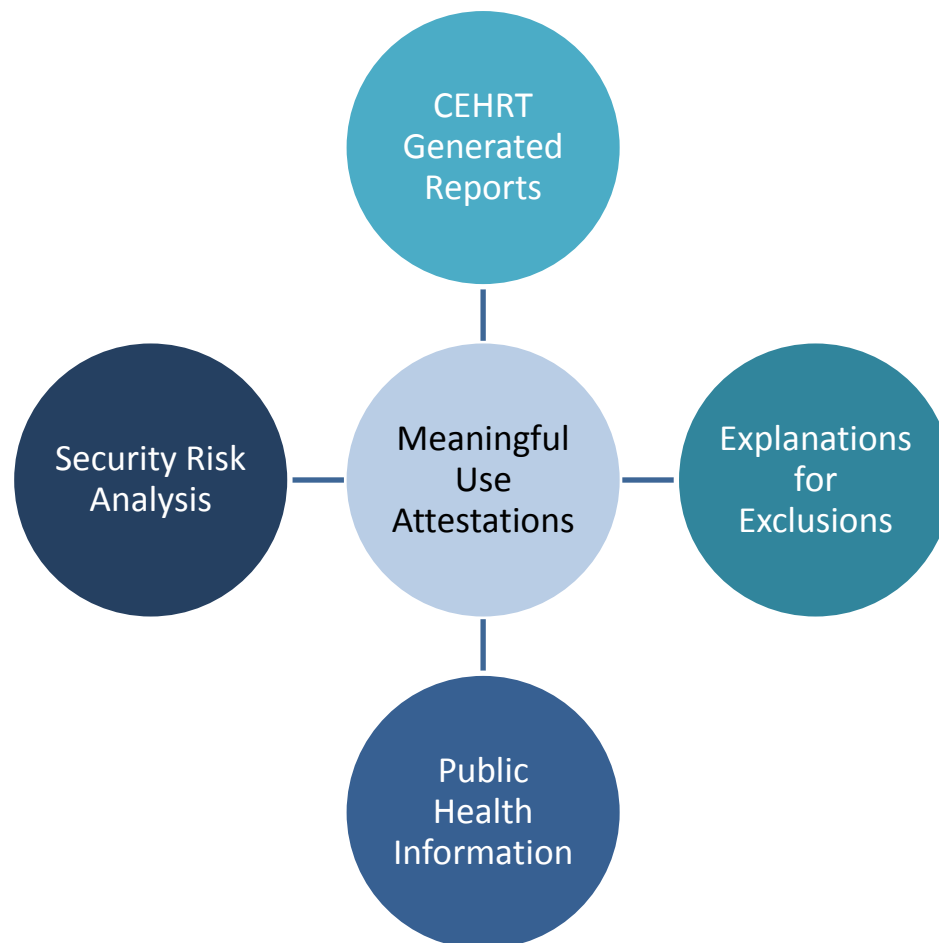
Eligible Professional Supporting Documentation for Attestation and Audit

Reminders and Best Practices

Reminders and Best Practices

✓ Prepare from the start! Create an attestation file with your supporting documentation.

✓ Be proactive! Upload Meaningful Use documentation at attestation.

✓ All information is subject to audit. Audit can be an unannounced onsite visit.

✓ Some documentation must be submitted at attestation.

✓ If audited, contact your auditor for questions on what to submit.

✓ Maintain all supporting documentation for 6 years post-attestation.

Questions?

- Click on the message icon 💬 to view the chat window.

- Type your questions into the chat window.

Eligible Professional Supporting Documentation for Attestation and Audit

Appendix

Supporting Documentation Table
Modified Stage 2 Meaningful Use (2015–2017)

Requirement	Objective/Measure	Examples of Supporting Documentation
Must report and meet the required threshold or answers for all general requirements and measures	General requirements 01-02 Measure for Objectives 03-09	• Meaningful Use dashboard reports produced by certified electronic health record technology (CEHRT) • Documentation on how the attestations were created, specifically how the numerators and denominators were calculated, including rationale taken into account for inclusion/exclusion of data • Electronic medical record for a Medicaid member verifying required measures have been captured electronically in the CEHRT
General Requirement 02: Percentage of CEHRT Use	Must have 50 percent or more of their patient encounters during the EHR reporting period at a practice location or practice locations equipped with CEHRT	• List of total encounters with detail including date, patient identifier, payer, and rendering provider • List of encounters with CEHRT with detail on location and CEHRT used
General Requirement 02: Unique Patients in CEHRT	Must have 80 percent or more of their unique patient data in the CEHRT during the EHR reporting period	• List of all unique patients with indication of whether they are in CEHRT (If practicing at multiple locations, indicate which patients were seen in which location.)

Note: This information comes from the ForwardHealth Online Handbook. Refer to the Meaningful Use of Certified EHR Technology section of the handbook at www.forwardhealth.wi.gov for the most up-to-date version of this table.

Supporting Documentation Table

Requirement	Objective/Measure	Examples of Supporting Documentation
Objective 1: Protect Patient Health Information	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of electronic protected health information (ePHI) created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the Eligible Professional's risk management process.	• Detail on security risk analysis including, but not limited to: ✓ Approach for assessment ✓ Results of the assessment ✓ Indication of who performed the assessment • Detail on security update performed as a result of the security risk analysis including, but not limited to: ✓ Update made ✓ Date made

Supporting Documentation Table

Requirement	Objective/Measure	Examples of Supporting Documentation
Objective 2: Clinical Decision Support (CDS), Measure 1	Implement five CDS interventions related to four or more clinical quality measures (CQMs) at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs related to an Eligible Professional's scope of practice or patient population, the CDS interventions must be related to high-priority health conditions.	• Description of which CDS interventions have been implemented with explanation of how the CDS interventions are aligned with four or more CQMs (documentation should be uploaded pre-payment) • Audit log showing the enabling of the CDS functionality with the time and date stamp • Screenshots from CEHRT demonstrating implementation of the CDS rules
Objective 2: CDS, Measure 2	The Eligible Professional has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.	• Audit log showing the enabling of the drug-drug and drug-allergy interaction checks with a time and date stamp • Screenshots from the CEHRT demonstrating the drug-drug and drug-allergy interaction checks • Documentation on exclusion qualification—proof the Eligible Professional wrote fewer than 100 medication orders during the EHR reporting period

Supporting Documentation Table

Requirement	Objective/Measure	Examples of Supporting Documentation
Objective 3: Computerized Provider Order Entry (CPOE), Measure 1: Medication Orders	More than 60 percent of medication orders created by the Eligible Professional during the EHR reporting period are recorded using computerized provider order entry.	• Random sampling of patient records • Rationale for exclusion or inclusion of patient records • List of individuals who entered CPOE with their credentials • Policies and procedures on CPOE • Documentation on exclusion qualification—proof they wrote fewer than 100 medication orders
Objective 3: CPOE, Alternate Measure 1: Medication Orders	For providers scheduled for Stage 1 in 2015: • For Stage 1 providers in 2015, more than 30 percent of all unique patients with at least one medication in their medication list seen by the Eligible Professional during the EHR reporting period have at least one medication order entered using CPOE. • More than 30 percent of medication orders created by the Eligible Professional during the EHR reporting period are recorded using CPOE.	• Random sampling of patient records • Rationale for exclusion or inclusion of patient records • List of individuals who entered CPOE with their credentials • Policies and procedures on CPOE • Documentation on exclusion qualification—proof they wrote fewer than 100 medication orders

Supporting Documentation Table

Requirement	Objective/Measure	Examples of Supporting Documentation
Objective 3: CPOE, Measure 2: Laboratory Orders	More than 30 percent of laboratory orders created by the Eligible Professional during the EHR reporting period are recorded using computerized provider order entry.	• Random sampling of patient records • Rationale for exclusion or inclusion of patient records • List of individuals who entered CPOE with their credentials • Policies and procedures on CPOE • Documentation on exclusion qualification—proof they wrote fewer than 100 laboratory orders
Objective 3: CPOE, Measure 3: Radiology Orders	More than 30 percent of radiology orders created by the Eligible Professional during the EHR reporting period are recorded using computerized provider order entry.	• Random sampling of patient records • Rationale for exclusion or inclusion of patient records • List of individuals who entered CPOE with their credentials • Policies and procedures on CPOE • Documentation on exclusion qualification—proof they wrote fewer than 100 radiology orders

Supporting Documentation Table

Requirement	Objective/Measure	Examples of Supporting Documentation
Objective 4: Electronic Prescribing (eRx)	More than 50 percent of all permissible prescriptions written by the Eligible Professional are queried for a drug formulary and transmitted electronically using CEHRT.	• Random sampling of patient records • Rationale for exclusion or inclusion of patient records • Rationale for exclusion or inclusion of prescriptions • Certified electronic health record technology screenshots verifying formularies utilized • Documentation on exclusion 1 qualification—proof they wrote fewer than 100 permissible prescriptions • Documentation on exclusion 2 qualification—on lack of pharmacies that accept electronic prescriptions within 10 miles of the Eligible Professional's practice location at the start of their EHR reporting period
Objective 4: eRx, Alternate Measure	For providers scheduled for Stage 1 in 2015, more than 40 percent of all permissible prescriptions written by the Eligible Professional are transmitted electronically using CEHRT.	• Random sampling of patient records • Rationale for exclusion or inclusion of patient records • Rationale for exclusion or inclusion of prescriptions • Documentation on exclusion 1 qualification—proof they wrote fewer than 100 permissible prescriptions • Documentation on exclusion 2 qualification—on lack of pharmacies that accept electronic prescriptions within 10 miles of the Eligible Professional's practice location at the start of their EHR reporting period

Supporting Documentation Table

Requirement	Objective/Measure	Examples of Supporting Documentation
Objective 5: Health Information Exchange	The Eligible Professional who transitions or refers her or his patient to another setting of care or provider of care must: 1. Use CEHRT to create a summary of care record. 2. Electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.	• Random sampling of patient records • Sample of a summary of care record • Rationale for exclusion or inclusion of patient records • Supporting documentation that the exchange mechanism complies with the privacy and security protocols for ePHI under the Health Insurance Portability and Accountability Act of 1996 • Log of exchange that took place during the EHR reporting period • Documentation on exclusion qualification—proof the Eligible Professional transfers or refers a patient to another setting of care or provider less than 100 times during the EHR reporting period
Objective 6: Patient-Specific Education	Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the Eligible Professional during the EHR reporting period.	• Documentation to show use of patient education based on information in the system (for example, screenshots or EHR-generated reports) • Sample of patient record indicating resources provided and rationale for the education resource—the connection to patient's clinically relevant information • Documentation on exclusion qualification—proof the Eligible Professional had no office visits during the EHR reporting period

Supporting Documentation Table

Requirement	Objective/Measure	Examples of Supporting Documentation
Objective 7: Medication Reconciliation	The Eligible Professional performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the Eligible Professional.	• Random sampling of patient records • Rationale for inclusion or exclusion of patient records • Documentation on exclusion qualification—proof the Eligible Professional was not the recipient of any transitions of care during the EHR reporting period
Objective 8: Patient Electronic Access, Measure 1	More than 50 percent of all unique patients seen by the Eligible Professional during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the Eligible Professional's discretion to withhold certain information.	• Eligible Professional Policy and Procedure documentation • Rationale for exclusion or inclusion of patient records • Documentation on how access was granted to patients within a set timeline • Electronic health record audit logs of patient access processing • Screenshots verifying existence of patient portal or electronic personal health record (ePHR) solution • Random sampling of patient records • Documentation on exclusion 1 qualification—rationale on how the Eligible Professional neither orders nor creates information listed for inclusion in the measure

Supporting Documentation Table

Requirement	Objective/Measure	Examples of Supporting Documentation
Objective 8: Patient Electronic Access, Measure 2	For an EHR reporting period in 2015 and 2016, at least one patient seen by the Eligible Professional during the EHR reporting period (or patient-authorized representative) views, downloads, or transmits his or her health information to a third party during the EHR reporting period. For an EHR reporting period in 2017, more than 5 percent of unique patients seen by the Eligible Professional during the EHR reporting period (or patient-authorized representatives) view, download, or transmit to a third party their health information during the EHR reporting period.	• Eligible Professional Policy and Procedure documentation • Rationale for exclusion or inclusion of patient records • Documentation on how access was granted to patients within a set timeline • Electronic health record audit logs of patient access processing • Random sampling of patient records • Documentation on exclusion 1 qualification—rationale on how the Eligible Professional neither orders nor creates information listed for inclusion in the measure • Documentation on exclusion 2 qualification—proof that 50 percent or more of the Eligible Professional's patient encounters take place in a county that does not have 50 percent or more of its housing units with 4 Mbps broadband availability

Supporting Documentation Table

Requirement	Objective/Measure	Examples of Supporting Documentation
Objective 9: Secure Electronic Messaging	For an EHR reporting period in 2015, the capability for patients to send and receive a secure electronic message with the Eligible Professional was fully enabled during the EHR reporting period. For an EHR reporting period in 2016, for at least one patient seen by the Eligible Professional during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or representative) or in response to a secure message sent by the patient (or representative) during the EHR reporting period. For an EHR reporting period in 2017, for more than 5 percent of unique patients seen by the Eligible Professional during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or representative) or in response to a secure message sent by the patient (or representative) during the EHR reporting period.	• Random sampling of patient records • Rationale for exclusion or inclusion of patient records • 2015: documentation that the functionality was fully enabled during the EHR reporting period • 2016: documentation that at least one patient was sent a secure messaging using the electronic messaging function of CEHRT during the EHR reporting period • Documentation on exclusion 1 qualification—proof the Eligible Professional had no office visits during the EHR reporting period • Documentation on exclusion 2 qualification—proof the Eligible Professional conducts at least 50 percent of his or her patient encounters in a county that does not have at least 50 percent of its housing units with 4 Mbps broadband availability according to the latest information available from the Federal Communications Commission on the first day of the EHR reporting period.

Supporting Documentation Table

Requirement	Objective/Measure	Examples of Supporting Documentation
Objective 10: Public Health Reporting, Measure 1: Immunization Registry Reporting	The Eligible Professional is in active engagement with a public health agency to submit immunization data.	• Documentation of the Eligible Professional's registration, onboarding, and/or ongoing submission with the Division of Public Health (DPH) • Documentation on exclusion 1 qualification—proof the Eligible Professional does not administer any immunizations to any of the populations for which data is collected by the DPH during the EHR reporting period
Objective 10: Public Health Reporting, Measure 2: Syndromic Surveillance Reporting	The Eligible Professional is in active engagement with a public health agency to submit syndromic surveillance data.	• Documentation of the Eligible Professional's registration, onboarding, and/or ongoing submission with the DPH • Documentation on the mechanism the Eligible Professional has chosen to report syndromic surveillance data • Documentation on exclusion 1 qualification—proof the Eligible Professional is not in a category of providers from which ambulatory syndromic surveillance data is collected by the DPH

Supporting Documentation Table

Requirement	Objective/Measure	Examples of Supporting Documentation
Objective 10: Public Health Reporting, Measure 3: Specialized Registry Reporting	The Eligible Professional is in active engagement to submit data to a specialized registry.	• Documentation of the Eligible Professional's registration, onboarding, and/or ongoing submission with the DPH or other specialized registry Note: See next slide for documentation on exclusions.

Supporting Documentation Table

Requirement	Objective/Measure	Examples of Supporting Documentation
Objective 10: Public Health Reporting, Measure 3: Specialized Registry Reporting (Continued)	The Eligible Professional is in active engagement to submit data to a specialized registry.	• Documentation on exclusion 1 qualification—proof that the Eligible Professional does not diagnose or treat any disease or condition associated with, or collect relevant data that is collected by, a specialized registry in her or his jurisdiction during the EHR reporting period (for example, cancer registry); both of the following actions must be documented to claim this exclusion: 　1. Determine whether the jurisdiction (state, territory, etc.) endorses or sponsors a registry. 　2. Determine whether a National Specialty Society or other specialty society with which the provider is affiliated endorses or sponsors a registry. • Documentation on exclusion 3 qualification—proof the Eligible Professional operates in a jurisdiction where no specialized registry for which the Eligible Professional is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period